State of Michigan
Department of Community Health
Michigan Automated Prescription System (MAPS)
P.O. Box 30202, Lansing, Michigan 48909
Phone: 517/373-1737 Fax: 517/636-6449 Email: Mapsinfo@michigan.gov

REQUEST FOR MAPS REPORT – Law Enforcement/Government Agency/Other

Practitioner or Patient Full Name: _____
First M.I. Last

Address: _____

City/State/Zip: _____

Date of Birth: _____ MI Prof. License #: _____ (if applicable) DEA #: _____ (if applicable)

SSN or Driver's License Number (if applicable): _____

Aliases and Other Addresses (if known): _____

Report Period Requested From: _____ Date to _____ Date

Provide a brief summary of the facts and circumstances under which you are requesting information regarding this practitioner or patient.

Case #:

(If you need additional space, please continue on the reverse side of this form.)

Agency Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ FAX Number: _____

Authorized Individual Name (print): _____

Signature of Authorized Individual: _____

I certify that this information shall be used only for bona fide drug-related criminal investigatory or evidentiary purposes; or for the investigatory or evidentiary purposes in connection with the functions of a disciplinary subcommittee of one or more of the licensing or registration boards created under Article 15. I shall not provide this information to any other person or entity except by order of a court of competent jurisdiction.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.
Authority: P.A. 231 of 2001
Completion: Voluntary

For Department of Community Health use only:

Approved: ☐ Yes ☐ No Signature _____ Date _____